OMB No. 0915-0275
Expiration Date 12/31/2004

# CLIENT DEMONSTRATION PROJECT: CLIENT-LEVEL FORM

*For definitions of terms used throughout this instrument, please refer to the accompanying Instruction Manual. (1) All providers are required to complete this instrument for each client served. (2) For all close-ended questions (questions with check-boxes) provide only ONE response per question unless instructed otherwise. (3) Please follow additional directions that appear next to some responses; these are instructions regarding skip patterns appropriate for specific response(s) to certain questions. (4) The data sent to HRSA should be cumulative, building each quarter so that by December 31st (or shortly thereafter), each client's record will contain comprehensive information about their care over the course of the entire year.*

## Client Level Information

**1. What is client's URN?** _____

**2. What is client's ZIP code?** _____

**3. What is the provider ID number?** _____

**4. Is the client a "new" client during this reporting period?**

0-☐ No
1-☐ Yes
9-☐ Unknown/unreported

**5. What is the client's gender?**

1-☐ Male
2-☐ Female
3-☐ Transgender
9-☐ Unknown/unreported

**6. What is the client's year of birth?**

Year of Birth: _____

**a. If year of birth is unknown, what is the client's estimated age?** Estimated age:_____

**7. Is the client of Hispanic or Latino/a ethnicity?**

0-☐ No
1-☐ Yes
9-☐ Unknown/unreported

**8. What is the client's race?** *(Check all that apply.)*

1-☐ White
1-☐ Black or African American
1-☐ Asian
1-☐ Native Hawaiian/Pacific Islander
1-☐ American Indian or Alaska Native
1-☐ Unknown/unreported

**9. What is the client's income?**

1-☐ Equal to or below the Federal poverty line
2-☐ 101–200% of Federal poverty line
3-☐ 201–300% of Federal poverty line
4-☐ > 300% of Federal poverty line
9-☐ Unknown/unreported

**10. What is the client's housing/living arrangement?**

0-☐ Permanently housed
1-☐ Non-permanently housed
2-☐ Institution
8-☐ Other
9-☐ Unknown/unreported

**11. What is the client's HIV/AIDS status?**

1-☐ HIV-positive, not AIDS
2-☐ HIV-positive, AIDS status unknown
3-☐ CDC-defined AIDS
4-☐ HIV-negative (affected clients only)
9-☐ Unknown/unreported

**12. What is the client's vital/enrollment status?**

1-☐ Active
2-☐ Deceased
3-☐ Inactive
9-☐ Unknown/unreported

**13. What is the client's source of medical insurance?**

1-☐ Private
2-☐ Medicare
3-☐ Medicaid
4-☐ Other public
5-☐ No insurance
8-☐ Other
9-☐ Unknown/unreported

**a. If "Other," describe**: _____

**14. What is client's primary risk factor for HIV infection?** *(Check only one.)*

1-☐ Male who has sex with male(s) (MSM)
2-☐ Injection drug user (IDU)
3-☐ Male who has sex with male(s) and injection drug user (MSM and IDU)
4-☐ Hemophilia/coagulation disorder
5-☐ Heterosexual contact
6-☐ Receipt of transfusion of blood, blood components, or tissue
7-☐ Mother with/at risk for HIV infection (perinatal transmission)
8-☐ Other
9-☐ Undetermined/unknown/risk not reported

**15. Does the client have a self-reported or documented history of substance abuse or dependency problems (including injection drugs, alcohol)?**

0-☐ No history (*Skip to #16.)*
1-☐ Yes, active history
2-☐ Yes, but not active
9-☐ Unknown/unreported (*Skip to #16.)*

**a. What is the client's current substance abuse treatment or counseling status?**

1-☐ In treatment with in-house primary care provider
2-☐ In treatment with psychiatrist or trained substance abuse professional
3-☐ No active treatment
8-☐ Other
9-☐ Unknown/unreported

**16. Does the client have a self-reported or documented history of a mental health condition?**

0-☐ No history (*Skip to #17.)*
1-☐ Yes, active history
2-☐ Yes, but not active
9-☐ Unknown/unreported (*Skip to #17.)*

**a. What is the client's current mental health treatment or counseling status?**

1-☐ In treatment with in-house primary care provider
2-☐ In treatment with psychiatrist or mental health professional
3-☐ No active treatment
8-☐ Other
9-☐ Unknown/unreported

## Service Information

*Please indicate the total number of visits (only services that were provided within your organization, do not record referrals) for each of the services listed below that were received by the client this year. If the client received no visits in a service category, record the total number of visits as zero.*

**17. Total number of visits received for each service:**

| Type of Service | Total Number of Visits |
|---|---|
| a. Ambulatory/outpatient medical care | _____ |
| b. Mental health services | _____ |
| c. Oral health care | _____ |
| d. Substance abuse services–Outpatient | _____ |
| e. Substance abuse services–Residential | _____ |
| f. Rehabilitation services | _____ |
| g. Home health: para-professional care | _____ |
| h. Home health: professional care | _____ |
| i. Home health: specialized | _____ |
| j. Case management services | _____ |
| k. Buddy/companion service | _____ |
| l. Child care services | _____ |
| m. Child welfare services | _____ |
| n. Client advocacy | _____ |
| o. Day or respite care for adults | _____ |
| p. Developmental assessment/early intervention services | _____ |
| q. Early intervention services for Titles I and II | _____ |
| r. Emergency financial assistance | _____ |
| s. Food Bank/home-delivered meals | _____ |
| t. Health education/risk reduction | _____ |
| u. Housing services | _____ |
| v. Legal services | _____ |
| w. Nutritional counseling | _____ |
| x. Outreach services | _____ |
| y. Permanency planning | _____ |
| z. Psychosocial support services | _____ |
| aa. Referral for health care/supportive services | _____ |
| ab. Referrals to clinical research | _____ |
| ac. Residential or in-home hospice care | _____ |
| ad. Transportation services | _____ |
| ae. Treatment adherence counseling | _____ |
| af. Other services | _____ |

**18. Please indicate the client's dates of the following:**

**a.** Initial HIV diagnosis: ___/_____ (mm/yyyy)

**b.** Entry into HIV primary medical care: ___/_____ (mm/yyyy)

**19. If client was new, did client enter HIV primary medical care as a result of counseling and testing services?** *(Check "Not applicable" if client is not new.)*

0-☐ No
1-☐ Yes, at this agency
2-☐ Yes, at another counseling and testing site
7-☐ Not applicable
9-☐ Unknown/unreported

## Medical Information

**For all questions in this section, except 28 and 29 (which are quarterly), the time period is anytime throughout the current calendar year (January 1 – December 31). All questions should be answered the first quarter and then updated as necessary throughout the rest of the year.**

**20. Was a screening/evaluation for HIV transmission risk behaviors conducted as part of the client's medical care?**

0-☐ No
1-☐ Yes
7-☐ Not applicable
8-☐ No, not medically indicated
9-☐ Unknown/unreported

**21. Was partner notification counseling included as part of the client's medical care?**

0-☐ No
1-☐ Yes, counseled on site by the primary care physician
2-☐ Yes, referred to another agency for counseling
7-☐ Not applicable
8-☐ No, not medically indicated
9-☐ Unknown/unreported

**22. Did the client receive a TB skin test?**

0-☐ No *(Skip to #23.)*
1-☐ Yes
7-☐ Not applicable *(Skip to #23.)*
8-☐ No, not medically indicated *(Skip to #23.)*
9-☐ Unknown/unreported *(Skip to #23.)*

**a. What was the result of the TB skin test?**

0-☐ Negative *(Skip to #23.)*
1-☐ Positive
9-☐ Unknown/unreported *(Skip to #23.)*

**b. Did the client receive treatment due to a positive TB skin test?**

0-☐ No
1-☐ Yes
9-☐ Unknown/unreported

**23. Did the client receive screening/testing for syphilis?**

0-☐ No *(Skip to #24.)*
1-☐ Yes
7-☐ Not applicable *(Skip to #24.)*
8-☐ No, not medically indicated *(Skip to #24.)*
9-☐ Unknown/unreported *(Skip to #24.)*

**a. What was the result of the syphilis screening test?**

0-☐ Negative *(Skip to #24.)*
1-☐ Positive
9-☐ Unknown/unreported *(Skip to #24.)*

**b. Did the client receive treatment for syphilis?**

0-☐ No *(Skip to #24.)*
1-☐ Yes
9-☐ Unknown/unreported *(Skip to #24.)*

**c. Was the Health Department contacted about the positive syphilis test?**

0-☐ No
1-☐ Yes
9-☐ Unknown/unreported

**24. Did the client receive screening/testing for any treatable sexually transmitted infection (STI), other than syphilis and HIV?**

0-☐ No *(Skip to #25.)*
1-☐ Yes
7-☐ Not applicable *(Skip to #25.)*
8-☐ No, not medically indicated *(Skip to #25.)*
9-☐ Unknown/unreported *(Skip to #25.)*

**a. What was the result of the STI (other than syphilis and HIV) screening test?**

0-☐ Negative *(Skip to #25.)*
1-☐ Positive
9-☐ Unknown/unreported *(Skip to #25.)*

**b. Did the client receive treatment for an STI (other than syphilis and HIV)?**

0-☐ No
1-☐ Yes
9-☐ Unknown/unreported

**25. If the client is anti-HAV negative, did the client receive hepatitis A vaccine (Havrix, Vaqta)?**

0-☐ No
1-☐ Yes, given vaccine
7-☐ Not applicable
8-☐ No, not medically indicated
9-☐ Unknown/unreported

**26. If the client is anti-HBV negative, did the client receive hepatitis B vaccine (Engerix-B, Recombivax)?**

0-☐ No
1-☐ Yes, given vaccine
7-☐ Not applicable
8-☐ No, not medically indicated
9-☐ Unknown/unreported

**27. Did the client receive screening/testing for hepatitis C?**

0-☐ No (*Skip to #28.)*
1-☐ Yes
7-☐ Not applicable (*Skip to #28.)*
8-☐ No, not medically indicated (*Skip to #28.)*
9-☐ Unknown/unreported (*Skip to #28.)*

**a. What was the result of the hepatitis C screening test?**

0-☐ Negative *(Skip to #28.)*
1-☐ Positive
9-☐ Unknown/unreported *(Skip to #28.)*

**b. Was the client referred for evaluation/treatment for hepatitis C?**

0-☐ No
1-☐ Yes
9-☐ Unknown/unreported

**28. Enter the most recent CD4+ lymphocyte count (cells/uL) test results for each quarter:**

_____ January–March
_____ April–June
_____ July–September
_____ October–December

**29. What was the client's lowest ever $CD4^+$ lymphocyte count (cells/μL) test result?**

_____ Count Date ___/_____ (mm/yyyy)

**30. What was the client's $CD4^+$ lymphocyte count (cells/μL) test result when the client first entered HIV primary medical care?**

_____ Count Date ___/_____ (mm/yyyy)

**31. Enter the most recent viral load (copies) test results for each quarter:**

_____ January–March
_____ April–June
_____ July–September
_____ October–December

**32. Which of the following best describes the client's antiretroviral therapy?**

0-☐ None
1-☐ None, not medically indicated
2-☐ None, patient refused
3-☐ None, patient not ready
4-☐ HAART, $1^{st}$ Regimen
5-☐ HAART, > $1^{st}$ Regimen
6-☐ Other (mono, dual, or other combination therapy)
9-☐ Unknown/unreported

**33. Did the client receive a pelvic exam?** *(If client is male, skip to #35.)*

0-☐ No
1-☐ Yes
7-☐ Not applicable
8-☐ No, not medically indicated
9-☐ Unknown/unreported

**34. Did the client receive a vaginal Pap smear?**

0-☐ No
1-☐ Yes
7-☐ Not applicable
8-☐ No, not medically indicated
9-☐ Unknown/unreported

**35. Did the client receive a rectal Pap smear?**

0-☐ No
1-☐ Yes
7-☐ Not applicable
8-☐ No, not medically indicated
9-☐ Unknown/unreported

**36. Was the client diagnosed with any of the following AIDS-defining conditions?**

| No | Yes | Unknown | |
|---|---|---|---|
| 0-☐ | 1-☐ | 9-☐ | Cervical cancer |
| 0-☐ | 1-☐ | 9-☐ | Cytomegalovirus disease |
| 0-☐ | 1-☐ | 9-☐ | Lymphoma |
| 0-☐ | 1-☐ | 9-☐ | Mycobacterium avium complex |
| 0-☐ | 1-☐ | 9-☐ | Mycobacterium tuberculosis |
| 0-☐ | 1-☐ | 9-☐ | Pneumocystis carinii pneumonia |
| 0-☐ | 1-☐ | 9-☐ | Toxoplasmosis |
| 0-☐ | 1-☐ | 9-☐ | Other AIDS-defining condition |

**37. Did the client receive Pneumocystis carinii pneumonia (PCP) prophylaxis?**

0-☐ No
1-☐ Yes
7-☐ Not applicable
8-☐ No, not medically indicated
9-☐ Unknown/unreported

**38. Did the client receive a pneumococcal vaccine?**

0-☐ No
1-☐ Yes
7-☐ Not applicable
8-☐ No, not medically indicated
9-☐ Unknown/unreported

**39. Was the client pregnant this year (January – December)?** *(If client is male, skip to #41.)*

0-☐ No *(Skip to #41.)*
1-☐ Yes
9-☐ Unknown/unreported *(Skip to #41.)*

**a. During what trimester did the client <u>enter</u> pre-natal care?**

1-☐ First trimester
2-☐ Second trimester
3-☐ Third trimester
4-☐ At time of delivery
9-☐ Unknown/unreported

**b. Did the client receive antiretroviral medications to prevent maternal to child transmission of HIV?**

0-☐ No
1-☐ Yes
9-☐ Unknown/unreported

**c. Did the client deliver any children this year (January – December)?**

0-☐ No *(Skip to #41.)*
1-☐ Yes
9-☐ Unknown/unreported *(Skip to #41.)*

**40. How many children were delivered to this client this year (January – December)?** _____

**a. Were any of the children HIV-positive?**

0-☐ No *(Skip to #41.)*
1-☐ Yes
2-☐ Indeterminate *(Skip to #41.)*
9-☐ Unknown/unreported *(Skip to #41.)*

**b. If yes, how many infants were HIV-positive?**

_____

**41. Was this client referred outside your EIS program (Title III) and/or your network (Title IV) for any service that was unavailable within your program or network this year?**

0-☐ No *(Client-level form complete.)*

1-☐ Yes

9-☐ Unknown/unreported *(Client-level form complete.)*

**42. Indicate the type of outside referral as well as whether the client received the service:**

| | Client Referred | | | *If client referred, please respond to this column.* Client Received Service | | |
|---|---|---|---|---|---|---|
| **Type of Service** | **No** | **Yes** | **Unknown** | **No** | **Yes** | **Unknown** |
| Ambulatory/outpatient medical care | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |
| Mental health services | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |
| Oral health care | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |
| Substance abuse services–Outpatient | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |
| Substance abuse services–Residential | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |
| Rehabilitation services | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |
| Home health: para-professional care | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |
| Home health: professional care | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |
| Home health: specialized | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |
| Case management services | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |
| Buddy/companion service | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |
| Child care services | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |
| Child welfare services | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |
| Client advocacy | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |
| Day or respite care for adults | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |
| Developmental assessment/early intervention services | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |
| Early intervention services for Titles I and II | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |
| Emergency financial assistance | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |
| Food Bank/home-delivered meals | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |
| Health education/risk reduction | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |
| Housing services | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |
| Legal services | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |
| Nutritional counseling | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |
| Outreach services | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |
| Permanency planning | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |
| Psychosocial support services | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |
| Referral for health care/supportive services | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |
| Referrals to clinical research | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |
| Residential or in-home hospice care | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |
| Transportation services | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |
| Treatment adherence counseling | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |
| Other services | 0-☐ | 1-☐ | 9-☐ | 0-☐ | 1-☐ | 9-☐ |

**CLIENT-LEVEL FORM COMPLETE.**